parent application, Applicants provide the following remarks to assist the Examiner in considering the pending claims.

Applicants respectfully submit that the pending claims, 1-35, distinguish from the prior art cited in the parent application. The final Office Action in the parent application at page 3, paragraph 6, took official notice that "it is old and well-known in the insurance art to pre-approve treatment for a patient." Applicants note that claim 1 of the present application recites the following acts, both of which are performed prior to the health care provider performing health care services:

> transmitting a proposed insurance claim that includes the diagnosis code and the treatment code from the client computer to the remote server computer prior to the health care provider performing health care services;
>
> determining, by the remote server computer, whether the proposed insurance claim is in condition to be paid, including performing the act of determining, by the remote server computer, whether the diagnosis code and the treatment code correspond to health care services that are approved for payment.

In view of the foregoing elements of claim 1, Applicants do not merely claim "pre-approving treatment for a patient." Instead, claim 1 recites a method by which a remote server computer determines whether a proposed insurance claim is in condition to be paid prior to the health care provider performing health care services. Without conceding that it was known in the insurance art to "pre-approve treatment for a patient," Applicants respectfully submit that any such pre-approval would have been limited to a labor-intensive process of a health care provider personally calling a representative of an insurance company by telephone to determine whether the patient's insurance plan covers the patient for certain treatments. For example, in the prior art of

which official notice was made, a surgeon would be required to call an insurance company representative by telephone to determine whether a patient is covered for, say, orthopedic surgery.

If the official notice of "pre-approval of treatment" is intended to be interpreted that it was well known in the insurance art to transmit and analyze proposed insurance claims prior to the health care provider performing health care services, the Applicants traverse this official notice. Applicants submit that there was no knowledge in the insurance art of transmitting and analyzing proposed insurance claims prior to health care services being performed, and no specific and pertinent reference was produced during prosecution of the parent application.

Applicants point out that the method of "pre-approval of treatment" of which official notice was made has several disadvantages, which are overcome by the present invention. For instance, even if the surgeon were to learn that a patient was covered for orthopedic surgery, such "pre-approval of treatment" would not ensure that an insurance claim prepared by the surgeon would be in condition to be paid. Pre-approval as cited by the official notice would do no more than give the surgeon some assurance that payment will eventually be made, but only upon the creation of a formal, acceptable insurance claim after the health care services are performed. "Pre-approval of treatment" as cited in the official notice does not involve an analysis of a proposed insurance claim as recited in claim 1. More specifically, the "pre-approval of treatment" of which official notice was made does not involve "determining, by the remote server computer, whether the proposed insurance claim is in condition to be paid", as recited in claim 1.

The specification of the present application, at page 5, lines 2-13, describes some of the problems associated with preparing insurance claims as experienced in the prior art. Applicants note that the following problems described in the specification of the present application are applicable even in situations in which the "pre-approval of treatment" of the official notice is

obtained and that these problems are overcome in accordance with the invention claimed in claim 1:

> The [insurance] claims can be rejected for any of a large number of informalities, including clerical errors, . . . indicia of fraud, etc. The health care provider is not made aware of the deficiencies of the submitted claims until a later date -- potentially weeks afterwards -- when the disposition of the insurance claim is communicated to the health care provider. As a result, many claims are subject to multiple submission and adjudication cycles, as they are successively created, rejected, and amended. Each cycle may take several weeks or more, and the resulting duplication of effort decreases the efficiency of the health care system. Studies have shown that some insurance claim submission systems reject up to 70% of claims on their first submission for including inaccurate or incorrect information or for other reasons. Many of the claims are eventually paid, but only after they have been revised in response to an initial rejection.

The clerical errors described above can, and frequently do, happen, regardless of whether the "pre-approval of treatment" of the official notice is obtained.

In contrast, the invention recited in claim 1 includes the act of "transmitting a proposed insurance claim . . . prior to the health care provider performing health care services." In this manner, the proposed insurance claim can be analyzed to make a determination, prior to the health care services being performed, as to whether the proposed insurance claim is in condition to be paid. Any clerical errors or the like, such as those that could exist regardless of whether "pre-approval of treatment" has been made, can be identified and corrected prior to the health care services being provided. In this manner the health care provider avoids being made aware of the deficiencies of the insurance claim at a later date, which would be potentially weeks afterwards.

This claimed method is not merely "pre-approval of treatment" of which official notice has been made in the parent application. As described below, Little also fails to disclose "transmitting a proposed insurance claim . . . prior to the health care provider performing health care services." For at least this reason, claim 1 of the present application distinguishes from the references cited in the final Office Action of the parent application.

The insurance claims of Little are submitted only after health care services are provided, regardless of whether the health care provider receives "pre-approval of treatment for a patient" as cited in the official notice. Little is generally directed to "a system for adjudicating health care payment requests" for "procedures and services [already] provided." (See Little, col. 5, lines 18-19; and col. 6, line 17-18). In contrast, the invention of claim 1 relates to interactively preparing a proposed insurance claim prior to performing health care services, and for informing a health care provider, prior to performing the health care services, whether the proposed insurance claim is in condition to be paid. Again, as noted above, the officially noted "pre-approval of treatment" also does not cause a health care provider to be informed, prior to health care services being performed, as to whether a proposed insurance claim is in condition to be paid.

As an initial matter, the method of Little is entirely consistent with the "pre-approval of treatment for a patient" of which official notice has been made in the parent application, in which a health care provider engages in a labor-intensive process of personally calling a representative of an insurance company by telephone to determine whether the patient's insurance plan covers the patient for certain treatments. In the example presented above, in the prior art of which official notice was made, a surgeon would be required to call an insurance company representative by telephone to determine whether a patient is covered for, say, orthopedic surgery. Assuming that one of skill in the art were motivated to combine this "pre-approval of treatment" with the claim

adjudication process of Little, this combination of references nonetheless fails to teach or suggest all of the limitations of claim 1. For instance, this combination fails to teach or suggest the act of:

> transmitting a proposed insurance claim that includes the diagnosis code and the treatment code from the client computer to the remote server computer prior to the health care provider performing health care services.

Combining the act of "pre-approval of treatment" with the method of Little merely results in a health care provider having the general knowledge that, if a formal and acceptable insurance claim were to be prepared after the health care services are provided, the insurance claim would be paid. This combination of references in no way eliminates the clerical errors or the like that can, and frequently do, result in attempted insurance claims prepared after the health care services are performed being rejected.

Turning now to the details of the method of Little, payment requests can be transmitted as electronic data through a network. (Col. 6, lines 53-56; Fig. 1, element 215). However, Little does not disclose transmitting insurance claims, diagnosis codes, treatment codes, or payment requests prior to a health care provider performing health care services. Instead, Little discloses a system for adjudicating health care payment requests using a computerized expert system (col. 5, lines 18-33) that was intended to replace or supplement conventional manual adjudication systems (col. 1, lines 43-63). Both conventional manual adjudication systems and the expert system of Little adjudicate payment requests under a payment model whereby health care providers create payment requests after health care services have been performed.

Little addresses the timing of the creation of the payment request only obliquely, since it was understood by those skilled in the art to which Little is directed that insurance claims could not

be created and adjudicated prior the health care provider performing health care services. For example, Little discloses that the "payment request . . . includes . . . a listing of procedures and supplied *provided* to the patient" (col. 6, lines 12-16; emphasis added) and that "[t]he process begins with the health care provider . . . submitting a request . . . for services and materials *provided* to a patient" (col. 6, lines 29-32; emphasis added). Both passages suggest health care services performed in the past, rather than after the creation of the payment request. In this manner Little teaches away from independent claim 1. Little addresses the timing of the creation of the payment request only in passing, since there was no understanding on part of Little of the concept of interactively preparing an insurance claim.

In contrast, the timing of transmitting the proposed insurance claim prior to the health care provider performing health care services as recited in claim 1 results in significant benefits that are not understood by Little nor in the "pre-approval of treatment" of which official notice was made. Transmitting the insurance claim in the manner recited in claim 1 enables the insurance claim to be interactively prepared, something that was not possible prior to the invention of claim 1.

Claim 1 also recites

> transmitting information from the remote server computer to the client computer prior to the health care provider performing the health care services, the information indicating to the health care provider whether the proposed insurance claim is in condition to be paid.

Little fails to disclose transmitting information of any kind from a remote server computer to a client computer associated with a health care provider. The only communication between computers in Little is represented by the payment requests, which can be transmitted as electronic data through a network as noted previously. However, the payment requests of Little flow in the

direction opposite that recited in the foregoing step of claim 1. In other words, the electronic communication between computers of Little is one-way. Irrespective of whether two-way communication is possible, no information is transmitted from the computers associated with the expert system to a computer associated with the health care provider. Based on the context of Little, this is to be expected; Little does not disclose interactive preparation of insurance claims, but rather simply discloses the transmission of payment requests from a health care provider to the adjudication system.

In addition to failing to disclose any kind of information being transmitted from a remote server computer to a client computer associated with a health care provider, Little also does not transmit information in any manner to a health care provider regarding whether the payment request will be honored prior to the health care provider performing health care services. Any indication given to the health care provider regarding the status of the payment request in Little clearly occurs after the health care services have been performed. For instance, Little states that "[o]nce the payer makes its payment decision, the payer writes a check or doesn't write a check to health care provider and the system ends." (Col. 6, lines 40-46). In Little, the indication that a payment request is not honored is made by the health care provider failing to receive a check, which represents one of the significant problems experienced by the prior art, including Little, which the invention recited in claim 1 overcomes. Rather than forcing the health care provider to guess at whether a particular insurance claim will be paid, the invention of claim 1 enables the insurance claim to be interactively prepared and allows the health care provider to learn of whether the proposed insurance claim is in condition to be paid prior to the health care provider performing the health care services. The health care provider can then adjust the treatment or correct clerical errors in the insurance claim as necessary to ensure payment for services rendered. This is a vast

improvement over the approach taken by Little, in which the health care provider learns of the non-acceptance of a payment request after the fact by failing to receive a check. (See Little, col. 6, lines 40-46).

For at least the foregoing reasons, Applicants respectfully submit that claim 1 distinguishes from Little and from the official notice of the parent application and request allowance thereof.

Each of the remaining independent claims, namely, claims 13, 18, 24, and 28, include limitations that relate to 1) communication of an insurance claim from a client computer to a server and 2) communication of information from the server to the client computer indicating to the health care provider whether the insurance claim is in condition to be paid, both occurring prior to the health care provider performing health care services. Thus, claims 13, 18, 24, and 28 also distinguish from Little and the official notice of the parent application for at least these reasons.

Each of the remaining claims, 2-12, 14-17, 19-23, 25-27, and 29-35, depends from one of the aforementioned independent claims, 1, 13, 18, 24 and 28, and thus incorporates all of the limitations of the respective independent claim from which it depends. Accordingly, Applicants respectfully submit that dependent claims 2-12, 14-17, 19-23, 25-27, and 29-35, are likewise in condition for allowance, for at least the reasons discussed with regard to independent claims 1, 13, 18, 24, and 28.

Furthermore, many of the dependent claims include limitations that further establish their patentability over Little. For instance, claim 3 includes the element:

> transmitting, from the remote server to the client computer, a suggested revised treatment code prior to the health care provider performing the health care services

Claim 34 includes similar limitations. This claimed feature enables the health care provider to include the treatment associated with the revised treatment code in the health care services so that the health care provider will be paid. In sharp contrast to this feature, Little provides no opportunity for interactive preparation of insurance claims, but instead merely "doesn't write a check" (col. 6, lines 41-42) when an original payment request is not payable. Moreover, Little does not disclose any suggested revised treatment codes, for good reason – when the adjudication system of Little receives an original payment request, the treatment has been performed and any opportunity for revision of the treatment has been lost. Applicants also note that the Examiner in the parent application has indicated that the limitation of claim 3 represents patentable subject matter. For this additional reason, claims 3 and 34 are allowable over Little.

Claim 4 recites, in connection with a previous determination that an original treatment code and a diagnosis code do not correspond to health care services that are approved for payment:

> incorporating the revised treatment code into the revised proposed insurance claim; . . .
>
> prior to the health care provider performing the health care services, transmitting, from the remote server to the client computer, information indicating to the health care provider that the diagnosis code and the revised treatment code correspond to health care services that are approved for payment.

Claims 14 and 35 recite similar limitations. With regard to claim 14, a revised proposed insurance claim has "at least one of a revised diagnosis code and a revised treatment code." These claimed features enable the health care provider to select a new treatment code or diagnosis code, to correct clerical errors or otherwise, that will result in the insurance claim being approved for payment prior to the health care services being performed. In contrast, Little provides no

opportunity for interactive preparation of insurance claims, but instead merely "doesn't write a check" (col. 6, lines 41-42) when an original payment request is not payable. Moreover, since the adjudication system of Little receives an original payment request only after the treatment has been performed, there is no disclosure or possibility of a "revised" treatment code. For this additional reason, claims 4, 14, and 35 are allowable over Little.

Claim 25 includes recites "prompting the health care provider to revise at least one of the diagnosis code and the treatment code prior to the health care provider performing the health care services". Claim 25 is therefore allowable over Little for the additional reasons presented above in reference to claims 3 and 4.

For at least the foregoing reasons, Applicants respectfully submit that pending claims 1-35 are in condition for allowance and courteously request favorable action.

Dated this 28th day of November, 2000.

Respectfully submitted,

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